# BENEFIT CHOICE ELECTION FORM

**June 7 – June 21, 2004** (Changes effective July 1, 2004)

**COMPLETE THIS FORM ONLY TO MAKE A CHANGE IN YOUR BENEFITS**

**SECTION A: EMPLOYEE INFORMATION (required)**

| Social Security Number | Last Name | First Name | Phone Numbers |
|---|---|---|---|
| - - | | | Home: |
| | | | Work: |

**SECTION B: OPT OUT / OPT IN**

| **OPT OUT/OPT IN of Health & Dental** | | |
|---|---|---|
| ☐ Opt Out | ☐ Opt In | **See Section B instructions on the instruction sheet for requirements.** |

**SECTION C: HEALTH PLAN ELECTIONS (complete only if changing your health)**

| **Health Plan Election *** | | |
|---|---|---|
| Quality Care Health Plan (QCHP) ☐ | | |
| Managed Care: ☐ HMO or ☐ OAP | | **If Managed Care is selected you must provide the physician's 6-digit Primary Care Provider (PCP) number.** |
| Carrier Code _____ (2 alpha characters) | PCP# _____ (6 numeric digits) | Plan Name _____ |

* You must complete a Coordination of Benefits Worksheet for yourself and/or any dependent who has other insurance coverage (including Medicare or Medicaid). The Coordination of Benefits Worksheet is available at www.benefitschoice.il.gov.

**SECTION D: DENTAL PLAN OPTION (complete only if electing not to participate in the dental plan)**

| **Dental Plan Option** |
|---|
| I choose not to participate in the dental plan ☐ |

**SECTION E: OPTIONAL LIFE INSURANCE (complete this section only if changing life coverage elections)**

| OPTIONAL LIFE | ☐ INCREASE | ☐ DECREASE | ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) | |
|---|---|---|---|---|
| ☐ CANCEL OPTIONAL LIFE | ☐ 1 x Basic | ☐ 3 x Basic | ☐ CANCEL AD&D | ☐ BASIC only (Basic) |
| | ☐ 2 x Basic | ☐ 4 x Basic | | ☐ COMBINED (Basic + Optional Life) |

**SECTION F: DEPENDENT INFORMATION [1] (dependent must be enrolled in the same plans as the member)**

| **HEALTH** | | | **LIFE [2]** ($5000) | | Name | SSN | Birth Date | Relationship [3] | **PCP #** (6 digits) |
|---|---|---|---|---|---|---|---|---|---|
| Add | Drop | Change | Add | Drop | | | | | |
| ☐ | ☐ | ☐ | ☐ | ☐ | | | | | |
| ☐ | ☐ | ☐ | ☐ | ☐ | | | | | |
| ☐ | ☐ | ☐ | ☐ | ☐ | | | | | |
| ☐ | ☐ | ☐ | ☐ | ☐ | | | | | |

**Notes:** [1] Documentation required to add dependents – see the instruction sheet for specific documentation requirements.

[2] Statement of Health form required when adding Spouse or Child Life (form available at www.benefitschoice.il.gov).

[3] Relationship must be spouse, son, daughter, stepchild, adopted child, adjudicated child or legal guardian.

I authorize prevailing premiums to be deducted from my pay or annuity for those plans I have selected. This authorization will remain in effect until I provide written notice to the contrary. The information contained in this form is complete and true. I agree to abide by all Group Insurance Program rules. I agree to furnish additional information requested for enrollment or administration of the plan I have elected.

MEMBER SIGNATURE: _____ DATE: _____

GIR/GIP SIGNATURE: _____ DATE: _____

**Give completed form to your GIR in your Benefits Office by June 21, 2004.**

# BENEFIT CHOICE ELECTION FORM
# INSTRUCTION SHEET

*If you are keeping your current coverage elections, you do not need to complete the Benefit Choice Election Form.*

**SECTION A – EMPLOYEE INFORMATION** (Complete all fields)

**SECTION B – OPT OUT / OPT IN**
If you wish to opt out of, or opt into, the State's Group Insurance coverage you must complete the 'Opt Out/Opt In' portion of Section B and submit an 'Opt Out/Opt In Election Certificate' (CMS-500 - form available at **www.benefitschoice.il.gov** or through your agency Group Insurance Representative). If you elect to opt out, you must also provide proof of comprehensive major medical health coverage (indemnity or managed care) provided by an entity other than the Department of Central Management Services. Proof of coverage may be a certificate of creditable coverage or a copy of the front and back of your health ID card.

**SECTION C – HEALTH PLAN ELECTIONS**
*Do not complete this section if you only want to change your Primary Care Physician (PCP) – you must contact your carrier directly in order to make this change.*

If you wish to change your **health** plan, you must check either the Quality Care Health Plan (QCHP) or one of the managed care plan boxes (HMO or OAP). If electing/changing managed care plans, you must enter the managed care plan's two-digit carrier code (see page 6 of the FY2005 Benefit Choice brochure for carrier codes), the plan's name, and the 6-digit PCP number. The 6-digit PCP number may be found in the managed care plan provider directory or the individual plan's online website (see pages 8 and 9 of the FY2005 Benefit Choice brochure for the Plan Administrator contact information).

**SECTION D – DENTAL PLAN OPTION**
If you wish to drop your **dental** coverage, you must check the 'I choose not to participate in the dental plan' box (proof of other dental coverage is not required). If you waive dental coverage, you can re-enroll only during the annual Benefit Choice election period or upon opting back into the health program.

**SECTION E – OPTIONAL LIFE INSURANCE**
Complete this section if you wish to add/drop/increase or decrease either your Optional Life[1] or Accidental Death and Dismemberment coverage.

**SECTION F – DEPENDENT INFORMATION**
Complete this section if you are adding, dropping or changing your dependent health or life[1] coverage. If you are adding health or life dependent coverage, **you must provide the appropriate documentation as indicated below**:

| | |
|---|---|
| Spouse | Marriage certificate |
| Natural Child through Age 18 | Birth certificate |
| Stepchild | Birth certificate, marriage certificate indicating your spouse is the child's parent, and proof the child resides with you at least 50% of the time. |
| Adopted Child | Adoption certificate stamped by the circuit clerk. |
| Adjudicated Child/Legal Guardian | Court documentation signed by a judge. |
| Student | Birth certificate, Dependent Coverage Certification Statement (CMS-138)**, and verification of full-time student enrollment in an accredited school. |
| Handicapped | Birth certificate, Dependent Coverage Certification Statement (CMS-138)**, and a letter from the doctor 1) detailing the dependent's limitations, capabilities and onset of condition from a cause originating prior to age 19, 2) a diagnosis from a physician with an ICD-9 diagnosis code, and 3) a statement from the Social Security Administration with the Social Security disability determination. |
| ** The Dependent Coverage Certification Statement (CMS-138) is available online at **www.benefitschoice.il.gov** or through your agency Group Insurance Representative (GIR). | |

[1] If you are applying to add or increase Optional Life, Spouse Life or Child Life, you must complete, sign and mail a Statement of Health application to ***Minnesota Life, 1 North Old Capitol Plaza, Suite 305, Springfield, IL 62701***. The Statement of Health application is available at **www.benefitschoice.il.gov** or through your agency GIR.

**SIGNATURE**
You must sign and date the Benefit Choice Election Form and give to your agency GIR by **June 21, 2004** in order for your elections to be effective July 1, 2004. Dependent documentation must be submitted to your GIR within 10 days of the end of the Benefit Choice Period. If documentation is not provided within the 10 day period your dependents will not be added.